PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council held Tuesday, March 22, 2005, 10:00 a.m., at the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Commissioner/Chair Paul Cote, Jr., Ms. Phyllis Cudmore, Mr.Albert Sherman, Ms. Janet Slemenda, Dr. Thomas Sterne, and Mr. Gaylord Thayer, Jr.. Absent were: Ms. Maureen Pompeo, Mr. Manthala George, Jr.,and Dr. Martin Williams. Also in attendance was Attorney Donna Levin, General Counsel.

Chair Cote announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance. In addition, Chair Cote noted that Docket Item #3, "Informational Briefing Concerning Proposed Regulations on Smoke-free Workplaces (105 CMR 661.000)" would not be heard until a future meeting of the Council.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Alfred DeMaria, Jr., M.D., Chief Medical Officer, Assistant Commissioner, Bureau of Communicable Disease Control, and State Epidemiologist, Massachusetts Department of Public Health; Ms. Susan Etkind, R.N., M.S., Director, Division of Tuberculosis Prevention and Control; Stephen Hughes, Director, Division of Community Sanitation; Attorney James Ballin, Deputy General Counsel, Office of the General Counsel; Paul Dreyer, Ph.D., Associate Commissioner, Center for Quality Assurance and Control; and Mr. Jere Page, Senior Analyst, Determination of Need Program.

PERSONNEL ACTIONS:

In a letter dated March 11, 2005, Blake M. Molleur, Executive Director, Western Massachusetts Hospital, Westfield, recommended approval of the reappointment of Rodney Larsen to the active medical staff of Western Massachusetts Hospital. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously) that, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the reappointment of Rodney Larsen to the active medical staff of Western Massachusetts Hospital be approved:

REAPPOINTMENT	MASS. LICENSE NO.:	STATUS/SPECIALTY:
Rodney Larsen, MD	38727	General Medicine/Geriatrics

In a letter dated March 14, 2005, Paul D. Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of reappointments to the various medical and allied health staffs of Lemuel Shattuck Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) that, in accordance with recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following reappointments to the various medical and allied health staffs of Lemuel Shattuck Hospital be approved:

REAPPOINTMENTS:	MASS. LICENSE NO.:	STATUS/SPECIALTY:
Tai Jin Chung, MD	34685	Active/Internal Medicine/Nephrology
Catherine Pierce, MD	60119	Consultant/Internal Medicine
Robin Reed, MD	54662	Active/Internal Medicine
David Stone, MD	54398	Active/Internal Medicine
Sami Erbay, MD	152649	Consultant/Radiology
Roger Graham, MD	70380	Consultant/Surgery
David Gansler, PhD	4912	Allied Health Professional/Psychology
Nancy Moczynski, PhD	6590	Allied Health Professional/Psychology
Marcia Sommer Winfrey, PA	198	Allied/Health Professional/Medicine

STAFF PRESENTATION: "UPDATE ON TUBERCULOSIS":

Dr. Alfred DeMaria, Chief Medical Officer, Assistant Commissioner, Bureau of Communicable Disease Control and State Epidemiologist, Department of Public Health, made introductory remarks. He said in part, "…It's been a long time since we have been here talking about Tuberculosis (TB) and in recognition of World TB Day, which is Thursday, and the 123rd anniversary of Robert Koch's announcement of the discovery of tubercle bacillus, it seemed appropriate to review Tuberculosis. We have a long history in Massachusetts of dealing with Tuberculosis, dealing with it well, and we have 2004 data today to present to you…"

Dr. DeMaria gave a brief overview of TB: "TB is transmitted when someone with active TB coughs and in doing so, generates droplets which then fly in the air, and people inhale those droplets, and that can lead to infection. That infection is usually not associated with illness, but is associated with a positive test, and most people who get infected, they and their germ die together because they don't develop active TB. It's only a small proportion of people who are infected, who have positive skin tests. Maybe one in twenty in the United States who has positive skin tests will go on, sometime in their lifetime, to develop active Tuberculosis, and then the cycle starts again. We talk about latent TB infection meaning somebody who doesn't have active TB, but has a positive skin test, and we talk about active infectious Tuberculosis which is what I think people think of when they think Tuberculosis. The key to Tuberculosis control is case finding and treatment. Early identification and diagnosis, with appropriate treatment, can render people non-infectious. And we do that very well in Massachusetts. We have done it very well for many years, and that we can document with the data. Basically, people in Massachusetts tend to have been exposed to areas or times when TB was at higher prevalence, and are much more likely to have acquired the initial infection elsewhere, or long ago. Secondly, when we investigate these cases, we know we are doing a good job of finding them and treating them because we don't find very many people who were exposed to the cases with positive skin tests. We are finding cases early and we are treating these."

"Finally," Dr. DeMaria stated, "there is epidemiological and molecular genetic evidence. We have fingerprinted the bacteria that we grow from active cases, and there is very little relationship among those bacteria suggesting that people acquired it from each other. Most of them are unique bacteria. We know that approach works. That is the approach we have used for many years and I think what we will come to, at the end of this presentation, is the conclusion that we need to do more to prevent

the active cases in the first place, and that is the key to the future control of Tuberculosis in Massachusetts."

Ms. Susan Etkind, R.N., M.S., Director, Division of Tuberculosis Prevention and Control, made a slide show presentation to the Council. She said in part, "…Tuberculosis is a disease that has historically been responsible for much of the world's morbidity from infectious diseases. One hundred and fifty years ago, TB killed one in three persons living in Massachusetts. In more recent years, with better control measures and the discovery of antibiotics, TB case rates in the United States, and in Massachusetts, had been steadily declining at a rate of approximately five percent per year. This trend has continued nationally but at a slower rate of decline in recent years; in fact, only 2.3% in 2004, but in Massachusetts a different picture has developed. In fact, from 1996 to 2003, case rates did not decrease, but remained stable. Had our case rates continued to decline at previous rates, we would have expected to have had approximately 667 cases during that period. Instead, we had over 2000 cases reported, and more than 1700 excess cases, that we would not have expected, based on the previous trends. In 2004, the number of TB cases actually rose by 9%. This is second only to 1998, when we had a ten percent increase in the number of cases. This is also the largest case rate increase in at least 15 years. The CDC has just released the 2004 National TB data, and Massachusetts is not alone. Eighteen other states also recorded increases in 2004, including our neighbors in Rhode Island and New Hampshire, and Massachusetts is now ranked twelfth in the nation in terms of morbidity."

Ms. Etkind continued, "This trend has continued into 2005. Comparing the same reporting week period in 2003, 2004, and 2005 to date, we can see the cause for concern. In 2004, 75% of the TB cases were among the non-US born. The absolute number of cases among this group has, in fact, remained stable over the last ten years. However, as cases among the US born White, Non-Hispanic population decline, cases among the Non-US born increase. Seventy percent of all reported cases are from the 23 largest communities in the State. Average case rates for some of these communities, such as New Bedford, Framingham, and particularly Quincy, are greater than that for Massachusetts overall. The numbers of TB cases among the Non-US born is a reflection of the fact that TB in many parts of the world is occurring in epidemic proportions. Dr. Nardell will describe this in more detail, but this slide paints the broad picture of the magnitude of the problem. Globally, there are billions of persons with TB infection, millions of persons with active TB disease, and millions of those who are infectious, and a significant proportion of who have either HIV or multi-drug resistant TB disease, and almost two million deaths occur from a disease that is treatable, curable, and preventable. We need to consider the global impact of Tuberculosis, maintain and now increase our vigilance and control efforts, while at the same time focusing on prevention."

Dr. Edward Nardell, Co-Chair, Massachusetts Medical Advisory Committee for the Elimination of Tuberculosis, stated in part, "TB is not declining globally. In fact, it is increasing in many parts of the world. Just to give you an order of magnitude while we are talking about four to five cases per hundred thousand in the United States, it's not out of the ordinary in many parts of the world, Africa, Asia, to have two hundred and fifty cases per hundred thousand. It's a throwback to when in Massachusetts Tuberculosis was the most common cause of death, and promises to get worse because of its links to the AIDS epidemic. Africa right now, sub-Saharan Africa in particular, has the highest rates of both Tuberculosis and AIDS, and it is definitely out of control. However, Asia has the largest population, and has had a Tuberculosis epidemic that has been raging for some time,

and the AIDS epidemic is just increasing in Asia. It promises to get much worse before it gets better. The other problem besides HIV, is multi-drug resistant Tuberculosis, which is common around the world, most dramatically in the ex-Soviet Union, in Russia and the former countries of the Soviet Union. All of these problems are reflected to a very small degree in the United States, in the fact that we have, every year obviously, immigrants, but also students, visitors, and moreover we travel to those countries. The potential for sharing in the world's TB burden is there, as Sue said, I think the answer to this is to think about this globally and the Center for Disease Control in Atlanta is doing that. They have invested a great deal of money in helping countries treat their Tuberculosis problem…"

Dr. Thomas Garvey, Co-Chair, Massachusetts Medical Advisory Committee for the Elimination of Tuberculosis, noted, "…Although Tuberculosis right now is having its deepest impact elsewhere, it is still very much a disease here, as well as a problem here. There are 15 million cases of latent TB in the United States today, and there are three hundred to six hundred thousand of these cases in Massachusetts. A substantial number of these people get active Tuberculosis if they are not treated. The rarity of TB in Massachusetts has been maintained and achieved by the hard work of the Division of Tuberculosis Prevention and Control. It is a network of outreach workers, TB surveillance nurses and clinics. I am going to explain why the state needs this, and what it does. First, why a special division for TB? TB is like cancer. Medications often feel worse than the disease. If you are a Tuberculosis patient, even if you have active TB, you will feel better after a few weeks of therapy and the drugs will make you vomit, break out in rashes, have headaches, diarrhea and, if they are not closely monitored, they can kill you. You will want to stop, and that would be a personal tragedy if we were talking about hypertension medication; but, in the case of tuberculosis, if you stop your medication, that is a public health threat and you can spread your resistant tuberculosis to people around you."

He continued, "…Massachusetts has had an outstanding TB program for decades. It works on many levels to ensure containment, treatment and prevention. First, the Division of TB prevention and control does community outreach and targeted testing and treatment for at-risk populations for latent TB, stopping it before it becomes active and contagious. There is also health provider education. Since the average health provider is going to see maybe one of these cases in twenty years, and if they are not looking for it, they won't recognize an outbreak, when a health professional reports an active case one of the five TB surveillance area nurses in the state orchestrates their response. The indexed case is quickly put on medications and becomes non-contagious within days. Family members and other close contacts, such as members of the same class in the school, are tested for TB, and those with very high likelihood of having TB are called TB suspects. TB suspects are treated as active cases until proven otherwise, and their contacts must be found, and usually there are three to four TB suspects for every confirmed active case of TB. With the 284 TB cases we had last year, there were over a thousand suspect cases, and they required nearly as many resources. Less intimate contacts who are found to have latent, that is non-contagious and inactive TB, are offered and, depending on the setting, sometimes required to take TB medications to prevent future outbreaks, and all patients with active TB must take a full course of medication and can be imprisoned for not doing so. But that is only the beginning. In most high prevalence areas of the Commonwealth, there are TB clinics, Centers of Excellence. In hospitals and community centers, doctors and nurses specially trained in TB management tailor a regimen suitable for each individual patient and carefully monitor them over the full course of treatment, which may last years. They

watch out for potentially deadly drug toxicities and interactions, and for signs of recurrent disease, which can be very subtle."

Dr. Garvey said further, "In regions without clinics, TB surveillance nurses will cooperate with the local boards of health and MDs to provide treatment and monitoring. Meanwhile, outreach workers, usually drawn from the community, will go house to house and watch patients with active TB take their medications, and that is called directly observed therapy, and that is the standard of care of TB treatment, set by the CDC and the World Health Organization. This goes on all the time in our cities and towns, but because of patient confidentiality, we usually don't hear about it. It is an epidemic that doesn't happen. The Commonwealth has had an exemplary program, a model for others across the country for decades. In the past, other places, such as New York City, have cut their specialized TB services. New York City did that in the eighties, and in the late eighties and early nineties they had a disastrous multi-drug resistant TB epidemic. It claimed two hundred and seventy lives, debilitated many more, and cost upwards of millions of dollars to stop, and they are still cleaning up. That epidemic barely affected Massachusetts because we maintained our excellent program."

In closing, Dr. Garvey said, "TB is a disease that is always poised to make a comeback. It is not just overseas. Our Division of TB Prevention and Control keeps it at bay, with community and provider outreach, rapid response to outbreaks, concentrated clinical expertise and individualized patient care, state-of-the-art."

In closing, Dr. DeMaria summarized in part, "…We are at a point where we don't have TB transmission to speak of in Massachusetts, so where are the increased number of cases coming from? People who have TB infection, where it wasn't recognized and they were not treated preventively, to prevent them from developing TB disease later on. Over the last ten years, we have made latent TB infection or a positive skin test a reportable condition. They will be starting to collect information on that to see how effectively people are screened, and how effectively they are treated for latent TB to prevent active disease. We also, this may seem counterproductive; we eliminated the requirement for teachers being tested for TB because that is a low risk population. There is a much higher risk of a false positive test and it was diverting attention and resources away from the key approach, and that is to find people at high risk of having TB infection and treating them. So, that is sort of how we are looking at what we need to do to get those rates down." Discussion followed by the Council. Dr. DeMaria noted that TB can stay latent for a lifetime or when there is some reduction in immunity because of HIV Infection or just the aging process, it can become active. Dr. DeMaria also said, "…We can prevent further cases, by finding people, by targeting, testing, and by treating the people who are at risk of developing Tuberculosis, not tomorrow, not next week, but five years from now, ten years from now. That is what we have to start doing because we have sort of taken case finding and treatment almost as far as we can go. We have to maintain that. That is critical." Other TB information noted:

- There is a whole new class of drugs that are being used for arthritis and other skin conditions such as psoriasis which are almost guaranteed to cause active TB if a person has the latent germ. In these cases, the person should be screened for TB prior to starting the medication.

- Living in a location where incidence of cases of TB is higher doesn't mean that the transmission of illness in that town is higher.

- A TB vaccine exists called BCG but it is not used in the United States. It has a 50% efficacy.

- There is a new diagnostic test, approved by the FDA (a blood test) available instead of the skin test now widely used to screen for TB. This blood test would not be influenced by BCG vaccination that can cause a false positive test result in the skin test.

NO VOTE/INFORMATION ONLY

REQUEST FOR PROMULGATION OF AMENDMENTS TO 105 CMR 410.000: MINIMUM STANDARDS OF FITNESS FOR HUMAN HABITATION (STATE SANITARY CODE CH. II):

Steven F. Hughes, Director, Community Sanitation Program, Center for Environmental Health, accompanied by Attorney James Ballin, Deputy General Counsel, Department of Public Health, presented the amendments to 105 CMR 410.000 to the Council. Staff noted, "On December 16, 2004, the Governor signed Chapter 417 of the Acts of 2004, entitled, *An Act Authorizing Water Submetering in Residential Tenancies (Act)*. This Act has now become law, codified as M.G.L.c.186§22, and will be effective March 16, 2005. The Act authorizes landlords of residential property to separately charge tenants for actual water and sewer service costs provided that all of the comprehensive requirements of the Act are met." Highlights of the Act:

- Prohibits water submetering unless the dwelling unit is separately submetered or, for single family rentals, the water usage is under the complete control of the tenant, to ensure that tenants are only charged for water actually used;

- Requires landlords to have licensed plumbers install any water submetering devices at the expense of the landlord;

- Requires landlords to certify in writing to the local board of health that the dwelling unit is in compliance with the requirements of the Act prior to separately charging for water or sewer service and to have a written agreement with tenants;

- Requires water conservation devices on all showerheads, sinks and toilets, at the landlord's expense, prior to separately charging for water or sewer service;

- Permits water submetering only in new tenancies created after the effective date of the Act, except that water submetering is not permitted in public housing dwelling units;

- Provides a process for tenants to report leaks, contest bills, and question the accuracy of water submeters and to only pay for water costs resulting from actual use;

- Requires landlords to remain as the water company customer and to be responsible for payment of water supplied by the water company;

- Prohibits landlords from shutting off water to a residential dwelling for non-payment of water or sewer costs but permits landlords to pursue all other legal remedies to collect bills, including deducting unpaid bills from security deposits;

- Authorizes the Department of Public Health to promulgate such additional regulations to the state sanitary code as it determines to be necessary to implement this section.

Mr. Hughes said, "The Community Sanitation Program presented the proposed amendments to 105 CMR 410.000 to the Council for informational purposes on January 18, 2005. A notice of the public hearing was published by the Secretary of State's Office and also appeared in two Massachusetts newspapers. A public hearing to solicit comments on the proposed regulations was held on March 2, 2005, in Boston. One person provided oral and written testimony during the hearing and provided supplementary written testimony after the hearing (Annette Duke from Massachusetts Law Reform Institute or MLRI). Four other individuals (Jason Godin, representing Ista [formerly known as Viterra Energy Services]; Frederic Hartwell, representing himself; Alice Moore from the Attorney General's Office; and Roxan McKinnon, representing the Boston Tenant Coalition) also provided written testimony.

Staff noted that this Act nullifies the Department of Public Health's 1990 Advisory Ruling and requires the Community Sanitation Program to amend the Housing Code in order to authorize submetering….Staff believes that the only necessary amendment to the Housing Code is to specifically authorize landlords to separately charge for water and sewer costs in accordance with the requirements of the Act.

Staff further noted, "The main change in the proposed amendments is to authorize separate bills to tenants for water service, in Section 410.180, and for sewer service, in 410.300. Section 410.180 repeats the prohibition in the Act on shutting off water due to non-payment to ensure that landlords are aware of this important prohibition to protect public health. For purposes of clarification, two definitions from the Act, one for "Water Conservation Device" and one for "Water Submetering" are added using the exact same language contained in the Act. In addition, Section 410.351 is revised to add 'submetering devices' to the list of owner-installed optional equipment for which an owner is responsible for maintaining and Section 410.354 is amended to allow submetering of 'water' in accordance with the Act in addition to electricity and gas currently listed in this section. One other minor clarification added to this amendment is to include the word 'potable' prior to the word 'water' in 410.180 to clarify that landlords are required under the Housing Code to provide potable water to their residential rental dwelling units."

Mr. Hughes noted that some of the comments submitted to the Department requested that the entire statute be included in the Housing Code to ensure that code enforcement officials, landlords and tenants all understand the requirements for water submetering without having to reference an outside source of law. In short, Mr. Hughes, said, "…To repeat the full statutory language of the Water Submetering Law, and all other laws referenced in code, would make the Housing Code excessively long and inaccessible to many users. To repeat most of the language, but not all, may

cause even more confusion. To address this concern, the Community Sanitation Program has added language to the final regulation that repeats only the main requirements of the Submetering Law, without including all the details of the statute. To ensure that property owners, tenants, code enforcement officials, and others are aware of this new law and its requirements, the program intends to provide both written guidance and trainings on the requirements of the new law. Five training sessions, primarily intended for code enforcement officials, have been scheduled throughout the state, starting in April of this year, in conjunction with the Massachusetts Health Officers Association. The program will provide additional trainings as needed to educate the public concerning the new law. The program also intends to provide written guidance that provides a clear and concise description of the statutory requirements for water submetering, that will widely be distributed to municipalities and housing organizations, as well as posted on the DPH Community Sanitation Web Site…"

Discussion followed by the Council around the water saving devices that as part of the statute must be installed at the landlord's expense. Attorney James Ballin added in part, "There is a requirement that the landlord get a certification form from a licensed plumber stating that they did indeed install a water conservation device." Dr. Sterne requested that an amendment be made to these final regulations today requiring that the landlord show the renter the certification form at the signing of the rental agreement. Council Member Sherman made the motion to include this amendment.

After consideration, upon motion made and duly seconded, it was voted unanimously to approve with an amendment as noted above the **Request for Promulgation of Amendments to 105 CMR 410.000: Minimum Standards of Fitness for Human Habitation (State Sanitary Code Ch. II); that a copy be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as Exhibit No. 14, 805.**

REQUEST FOR EMERGENCY PROMULGATION OF PROPOSED AMENDMENTS TO THE SUITABILITY REVIEW PROCESS HSA V PILOT PROJECT (105 CMR 153.022 (B)):

Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control, presented the emergency request of proposed amendments to the Suitability Review Process HSA V Pilot Project to the Council. He noted, "The Division of Health Care Quality requests emergency promulgation of proposed amendments to the Long Term Care Facility Licensure Procedure and Suitability Requirements at 105 CMR 153.022 (B). The proposed amendments will make permanent the suitability review HSA V project. Under the current regulations, the project expires on March 31, 2005. With emergency promulgation, there will be no lapse in the project pending publication in the Massachusetts Register of the final regulation. This project established in February 1990, instituted a public notice and hearing process prior to transfers of ownership for long term care facilities located in HSA V. The project is part of the suitability review process for prospective owners/licensees of long term care facilities. Since 1990, 98 public notices of intent to acquire a long term care facility in HSA V have been published. As a result of these notices, 32 hearings have been requested by residents of HSA V and conducted by the Department."

It was further noted, in staff memorandum dated March 22, 2005, "The proposed amendments also add family councils to the hearing notification requirements. Recent amendments to the Massachusetts General Laws require nursing facilities to allow the formation of family councils. The proposed amendment to 105 CMR 153.022 (B)(2)(b) would require the current facility owner or licensee to notify a family council, if there is one, of any hearing scheduled regarding the transfer of ownership." Dr. Dreyer said, "The Department will conduct a comment period and hold a public hearing on the proposed amendments and return to the Council for final promulgation."

A brief discussion followed, Ms. Slemenda, Council Member asked why this is only put in place for HSA V? Dr. Dreyer responded, "My recollection is in 1990, there was interest from community organizations on the Cape in trying this out, and so I think there was an agreement at that time to try it out on a pilot basis, the hearings were well attended. Folks came and testified. It gave people a chance to talk about their view of the proposed nursing home owner. The information provided to the Department was not necessarily determinative in our decision-making about whether to approve or not approve the new owners. From our point of view, it enables folks in the community to make their views known but there didn't seem to be interest elsewhere in a similar process."

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the Request for **Emergency Promulgation of Proposed Amendments to the Suitability Review Process HSA V Pilot Project (105 CMR 153.022 (B))**; that a copy be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit No. 14, 806**

DETERMINATION OF NEED:

PROJECT APPLICATION NO. 4-3A59 OF HEBREW CENTER FOR THE AGED, INC.:

Mr. Jere Page, Senior Analyst, Determination of Need Program, presented the Hebrew Rehabilitation Center for the Aged, Inc. to the Council. He said, "…This project before you is seeking approval for construction of a 240 bed satellite chronic rehabilitation hospital in Dedham, to replace and relocate 240 existing licensed chronic disease care beds from the 675-bed Hebrew Rehabilitation Center for the Aged in Roslindale. The project is intended to address the need of the applicant and maintain its existing bed capacity and also accommodate its more medically complex patient caseload in a safe and effective manner. The applicant reports the existing physical plant in Roslindale no longer meets the programmatic and care related needs of its patient population. For example, the typical patient in the facility is eighty-seven years old, and a long-term care admission with chronic illness, with significant physical or behavioral implications. These patient needs are wheelchairs, lifts, and other special equipment, which require significant additional space in patient rooms and activity areas. However, the gross square feet per bed in the existing facility is only five hundred and thirty-three gross square feet per bed. That is not much larger than a typical nursing home in Massachusetts, and it is undersized when compared to the patient requirements for care of the hospital's chronically ill patients. It is expected that the proposed satellite facility will be completed by June 2008. The recommended maximum capital expenditure is $63,756,494 (July 2003 dollars) which will be financed through an equity

contribution of $7.5 million by the applicant by available investment funds. The remaining MCE of 56 million dollars will be financed by tax exempt bonds issued by either the Mass Health and Educational Facilities Authority or the Massachusetts Development Finance Program."

In conclusion, Mr. Page stated, "Staff is recommending approval of this project with the conditions indicated on Page 9 of the staff summary. There are only four conditions; the MCE, the space, the amount of equity and interpreter services…"

Mr. Leonard Fishman, CEO and President, Hebrew Rehabilitation Center, addressed the Council. Mr. Fishman testified, "This project is critical to our future. The quality of staff and the quality of care of Hebrew Rehabilitation Center is known throughout Massachusetts and indeed throughout the country. We are very proud of our reputation. However, the physical plant is frankly obsolete. It was built for a population, when it opened forty years ago, that was relatively mobile, and cognitively intact. Residents spent very little time in their rooms and, consequently, the rooms were built to a size that was essentially like a dormitory room. The average double bedded room in one of our two major buildings is 182 square feet, which is smaller than what a single bedded room would be if it were built today. It is not only inconvenient for residents, but it presents problems in terms of moving residents who are not mobile, having the adequate equipment that we need in the rooms, and so on. The purpose here is to replace 240 beds that are obsolete with 240 beds that will suit the needs of the increasingly frail population we are caring for now and will care for in the future."

Discussion followed by the Council. Council Member Thayer, Jr. asked the applicant if the project would be funded privately. The applicant replied yes – through tax exempt bonds. Dr. Sterne commented on the larger project which includes, independent living, assisted living and a grade school on campus.

In conclusion, Mr. Fishman said, "…Our goal is to avoid providing long term care to anyone who can live in the community, either in their own homes or in supportive housing, or assisted living…"

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve **Project Application No. 4-3A59 of Hebrew Center for Aged, Inc.**; based on staff findings, with a maximum capital expenditure of $63,756,494 (July 2003 dollars) and first year operating costs of $5,157,205 (July 2003 dollars). A staff summary is attached and made a part of this record as **Exhibit No. 14, 807.** As approved, the application provides for new construction of a 240-bed hospital satellite facility in Dedham to replace and relocate 240 existing licensed chronic disease care beds from the 675-bed Hebrew Rehabilitation Center for Aged in Roslindale. The beds will be relocated from 1200 Centre Street in Roslindale to 45 West Street and 600 and 640 Common Street in Dedham, MA. The remaining licensed bed capacity at the existing Roslindale facility will be 435 chronic disease care beds and 46 skilled nursing beds. This Determination is subject to the following conditions:

1. The Applicant shall accept the maximum capital expenditure of $63,756,494 (July 2003 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR

100.751 and 752.

2. The total gross square feet (GSF) for this project shall be a total of 221,695 GSF to replace and relocate 240 existing licensed chronic disease care beds, and associated support services.

3. The Applicant shall contribute 11.7% in equity ($7,500,000 in July 2003 dollars) to the final approved MCE.

4. With regards to its interpreter service, the Applicant shall:

    - Submit a plan and timeline to reach out to the agencies and natural support groups of new Limited English Proficiency ("LEP") communities to ensure their members have first hand information about the Hospital's services and the availability of interpreter services.

    - Adapt the Hospital's data collection system to include language, race, and ethnicity information about patients.

    - Submit a plan and timeline for staff training on new policies and procedures, data collection and tracking for interpreter services.

    - Provide opportunities for all LEP patients to have input into the patient surveys.

    - Assure the Office of Multicultural (OMH) that all posters stating the availability of interpreter services have an English equivalent and are placed at all public points of entry.

    - Include protections for employee volunteers in hospital policy.

A plan to address these interpreter service elements shall be submitted to OMH within 120 days of the DoN approval. In addition, the Applicant shall notify OMH of any substantial changes to its Interpreter Services Program, and progress reports shall be submitted annually to OMH on the anniversary date of the DoN approval. Also, the Applicant shall follow recommended National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care.

Staff's recommendation was based on the following findings:

1. The applicant is proposing new construction of a 240-bed hospital satellite facility in Dedham to replace and relocate 240 existing licensed chronic disease care beds from the 675-bed Hebrew Rehabilitation Center for Aged in Roslindale.

2. The health planning process for the project was satisfactory.

3. The proposed new construction is supported by the Applicant's need to accommodate its increasingly complex patient caseload in a safe and effective manner, as discussed under

the Health Care Requirements Factor of the Staff Summary.

4. The project, with adherence to a certain condition, meets the operational objectives factor of the DoN Regulations.

5. The project, with adherence to a certain condition, meets the standards compliance factor of the DoN Regulations.

6. The recommended maximum capital expenditure of $63,756,494 (July 2003 dollars) is reasonable compared to similar, previously approved projects.

7. The recommended operating costs of $5,157,205 (July 2003 dollars) are reasonable compared to similar, previously approved projects.

8. The project is financially feasible and within the financial capability of the applicant.

9. The project meets the relative merit requirements of the DoN Regulations.

The meeting adjourned at 11:10 a.m.

_____
Paul J. Cote, Jr.
Chair

LMH/lmh